SERFF Tracking Number:	*AEGX-126244057*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*43046*
Company Tracking Number:	*HH AR0046715C01*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*Limited Benefit*		
Project Name/Number:	*Limited Benefit/HH AR0046715C01*		

Filing at a Glance

Company: Stonebridge Life Insurance Company

Product Name: Limited Benefit	SERFF Tr Num: AEGX-126244057	State: ArkansasLH
TOI: H14I Individual Health - Hospital Indemnity	SERFF Status: Closed	State Tr Num: 43046
Sub-TOI: H14I.000 Health - Hospital Indemnity	Co Tr Num: HH AR0046715C01	State Status: Approved-Closed
Filing Type: Form/Rate	Co Status:	Reviewer(s): Rosalind Minor
	Author: SPI ADMSLH	Disposition Date: 08/05/2009
	Date Submitted: 07/27/2009	Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: Limited Benefit
Project Number: HH AR0046715C01
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 08/05/2009

Deemer Date:

Filing Description:

July 27, 2009

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 08/05/2009
Corresponding Filing Tracking Number:

Insurance Commissioner Jay Bradford

Compliance - Life and Health

Arkansas Department of Insurance

SERFF Tracking Number:	*AEGX-126244057*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*43046*
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Product Name:	*Limited Benefit*		
Project Name/Number:	*Limited Benefit/HH AR0046715C01*		

1200 West Third Street
Little Rock, AR 72201-1904

RE: Form and Rate Filing - SLHI2000IP, et al.
Health Hospital Indemnity
Company Filing#: HH AR0046715C01
Stonebridge Life Insurance Company NAIC#: 468-65021 FEIN#: 03-0164230

Dear Commissioner Bradford:

The above captioned Limited Benefit Hospital Insurance Policy and related materials are being submitted for your review and approval. These forms are new and do not replace any forms previously approved by your department. These forms have been completed in "John Doe" fashion.

This individual policy provides a daily benefit for each day of confinement for care and treatment of childbirth for a covered pregnancy. The benefit will begin after a specified waiting period after the birth which can vary by type of delivery. The policy is guaranteed issue and non-cancelable.

Bracketed information throughout the policy and application form is intended to be variable. An explanation of variability is included.

The product will be marketed via direct response means, including mail, telephone solicitation and internet. We intend to use an electronic signature process for the customer's signature of the enrollment form in the telephone and internet channels, and will maintain records of sales of this product in a secure electronic format.

We trust with the enclosed information, you will be able to review our filing and grant an approval. If you have any questions, please contact the undersigned. Thank you in advance for your attention to this filing.

Sincerely,

Kimberly Taylor, AIRC, ACS

SERFF Tracking Number:	*AEGX-126244057*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*43046*
Company Tracking Number:	*HH AR0046715C01*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*Limited Benefit*		
Project Name/Number:	*Limited Benefit/HH AR0046715C01*		

Company and Contact

Filing Contact Information

Kimberly Taylor, Filing Specialist
520 Park Avenue
Baltimore, MD 21201

kimtaylor@aegonusa.com
(410) 209-5261 [Phone]
(410) 209-5910[FAX]

Filing Company Information

Stonebridge Life Insurance Company
29 South Main Street
Rutland, VT 05701-5014
(410) 685-5500 ext. [Phone]

CoCode: 65021
Group Code: 468
Group Name:
FEIN Number: 03-0164230

State of Domicile: Vermont
Company Type: Life and Health
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Stonebridge Life Insurance Company	$100.00	07/27/2009	29458510

SERFF Tracking Number:	*AEGX-126244057*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*43046*
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TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*Limited Benefit*		
Project Name/Number:	*Limited Benefit/HH AR0046715C01*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/05/2009	08/05/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	07/29/2009	07/29/2009	SPI ADMSLH	08/04/2009	08/04/2009

SERFF Tracking Number:	*AEGX-126244057*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*43046*
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Product Name:	*Limited Benefit*		
Project Name/Number:	*Limited Benefit/HH AR0046715C01*		

Disposition

Disposition Date: 08/05/2009
Implementation Date:
Status: Approved-Closed
Comment:

Company Name:	**Overall % Indicated Change:**	**Overall % Rate Impact:**	**Written Premium Change for this Program:**	**# of Policy Holders Affected for this Program:**	**Written Premium for this Program:**	**Maximum % Change (where required):**	**Minimum % Change (where required):**
Stonebridge Life Insurance Company	%	%	$		$	%	%

SERFF Tracking Number:	*AEGX-126244057*	*State:*	*Arkansas*
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Product Name:	*Limited Benefit*		
Project Name/Number:	*Limited Benefit/HH AR0046715C01*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	AR - NAIC TRANSMITTAL DOCUMENT, AR - NAIC FORM FILING ATTACHMENT, AR - NAIC RATE FILING ATTACHMENT	Approved-Closed	Yes
Supporting Document	Explanation of Variability	Approved-Closed	Yes
Form *(revised)*	Limited Benefit Hospital Insurance Policy	Approved-Closed	Yes
Form	Limited Benefit Hospital Insurance Policy	Replaced	Yes
Form	Limited Benefit Hospital Insurance Application	Approved-Closed	Yes
Form *(revised)*	Limited Benefit Hospital Insurance Outline of Coverage	Approved-Closed	Yes
Form	Limited Benefit Hospital Insurance Outline of Coverage	Replaced	Yes
Rate	Limited Benefit Hospital Insurance Actuarial Rate Sheet	Approved-Closed	Yes

SERFF Tracking Number:	*AEGX-126244057*	*State:*	*Arkansas*
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Product Name:	*Limited Benefit*		
Project Name/Number:	*Limited Benefit/HH AR0046715C01*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	07/29/2009
Submitted Date	07/29/2009
Respond By Date	

Dear Kimberly Taylor,

This will acknowledge receipt of the captioned filing.

Objection 1

- Limited Benefit Hospital Insurance Policy (Form)

Comment:

There needs to be a provision for the refund of unearned premium in the event of death of the insureds. Please refer to ACA 23-85-134.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	08/04/2009
Submitted Date	08/04/2009

Dear Rosalind Minor,

Comments:
Thank you for reviewing our filing. The following is in response to your objection letter dated July 29, 2009.

Response 1

Comments: Objection 1

Pursuant to ACA 23-85-134, we have included a provision for the refund of unearned premium in the event of the death of the Insured in the policy and outline of coverage.

SERFF Tracking Number:	*AEGX-126244057*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*43046*
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TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*Limited Benefit*		
Project Name/Number:	*Limited Benefit/HH AR0046715C01*		

Please note forms SLHI2000IP.AR and SLHI2000IOC.AR are replacing forms SLHI2000IP and SLHI2000IOC.

Related Objection 1

Applies To:

- Limited Benefit Hospital Insurance Policy (Form)

Comment:

There needs to be a provision for the refund of unearned premium in the event of death of the insureds. Please refer to ACA 23-85-134.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Limited Benefit Hospital Insurance Policy	SLHI2000IP.AR		Policy/Contract/Fraternal Certificate	Revised		46	SLHI2000IP_AR.PDF
Previous Version							
Limited Benefit Hospital Insurance Policy	*SLHI2000IP*		*Policy/Contract/Fraternal Certificate*	*Initial*		*46*	SLHI2000IP.PDF
Limited Benefit Hospital Insurance Outline of Coverage	SLHI2000IOC.AR		Other	Revised		40	SLHI2000IOC_AR.PDF
Previous Version							
Limited Benefit Hospital Insurance Outline of Coverage	*SLHI2000IOC*		*Other*	*Initial*		*40*	SLHI2000IOC.PDF

No Rate/Rule Schedule items changed.

We believe these revisions will assist in your further review and with optimism, subsequent approval. Your time and consideration regarding this filing is greatly appreciated.

SERFF Tracking Number:	*AEGX-126244057*	*State:*	*Arkansas*
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Product Name:	*Limited Benefit*		
Project Name/Number:	*Limited Benefit/HH AR0046715C01*		

Sincerely,

Kimberly Taylor, AIRC, ACS

Sincerely,
SPI ADMSLH

SERFF Tracking Number:	*AEGX-126244057*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*43046*
Company Tracking Number:	*HH AR0046715C01*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*Limited Benefit*		
Project Name/Number:	*Limited Benefit/HH AR0046715C01*		

Form Schedule

Lead Form Number: SLHI2000IP

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	SLHI2000IP.AR	Policy/Contract/Fraternal Certificate	Limited Benefit Hospital Insurance Policy	Revised	Replaced Form #: Previous Filing #:	46	SLHI2000IP_AR.PDF
Approved-Closed	SLHI2000IA	Application/Enrollment Form	Limited Benefit Hospital Insurance Application	Initial		40	SLHI2000IA.PDF
Approved-Closed	SLHI2000IOC.AR	Other	Limited Benefit Hospital Insurance Outline of Coverage	Revised	Replaced Form #: Previous Filing #:	40	SLHI2000IOC_AR.PDF

STONEBRIDGE LIFE INSURANCE COMPANY

A STOCK COMPANY
Home Office: Rutland, Vermont
Administrative Office: [2700 West Plano Parkway, Plano, Texas 75075**]**
Toll Free Number [1-800-527-9027**]**

LIMITED BENEFIT HOSPITAL INSURANCE POLICY

Stonebridge Life Insurance Company (herein called "we", "us" or "our") has issued this Policy to the Insured (herein called "you", "your", or "yours"). Coverage is provided to you, the Insured, subject to all terms of this Policy.

TABLE OF CONTENTS

NONCANCELABLE – SINGLE TERM NONRENEWABLE POLICY

You may keep this Policy in force, for as long as you live, subject to the When Your insurance Ends Provision. We can not cancel your coverage.

This Policy is not renewable. This Policy will remain in force until the conditions set forth in the When Your insurance Ends Provision occur. Please read the When Your insurance Ends Provision carefully.

YOUR RIGHT TO EXAMINE THE POLICY

If you are not satisfied with this insurance, you may return this Policy and cancel your coverage for any reason within 30 days of the date you receive this Policy. You may return this Policy to our Administrative Office. You will receive a full refund of any premium you have paid. The Policy is treated as if it never existed. No benefits are paid.

IN WITNESS, this Policy is signed by our President and Secretary.

Craig D. Vermie
Secretary

Marilyn Carp
President

THIS POLICY PROVIDES LIMITED BENEFITS ONLY

PLEASE READ CAREFULLY

POLICY SCHEDULE

INSURED: **[**Jane Doe**]**

POLICY NUMBER: **[**C12345**]** **SINGLE PREMIUM:** **[**$50.00**]**

POLICY EFFECTIVE DATE: **[**04-01-2009**]**

SCHEDULED DELIVERY DATE: **[**09-01-2009**]**

HOSPITAL CONFINEMENT BENEFIT FOR MATERNITY: $**[**50**]** per day
BENEFIT WAITING PERIOD: **[[**3**]** days after vaginal birth
[4**]** days after caesarian birth**]**
[7**]** days**]]**
MAXIMUM BENEFIT PERIOD: **[**30**]** days after Benefit Waiting Period

---

DEFINITIONS

BENEFIT WAITING PERIOD means a period of consecutive days of Hospital Confinement after birth for which no benefit is payable. The Benefit Waiting Period begins on the day you give birth during a Hospital Confinement for the Covered Pregnancy. The Benefit Waiting Period is shown on the Policy Schedule.

COVERED PREGNANCY means your pregnancy at the time your coverage goes into effect.

HOSPITAL means an institution which meets the following requirements:
1. It is operated pursuant to law; and
2. It is primarily engaged in providing or operating either on its premises or in facilities available to the Hospital on a prearranged basis and under supervision of a staff of one or more duly licensed Physicians, medical, diagnostic, and major surgical facilities for medical care and treatment of sick and injured persons on an inpatient basis; and
3. It provides 24 hour nursing service by or under the supervision of registered graduate professional nurses (R.N.s).

Hospital does not include an institution operated primarily as: a convalescent home, convalescent, rest, or nursing facility; or a facility primarily affording custodial or educational care; or a facility for the aged, drug addicts, or alcoholics. Hospital also does not include that part of an institution operated primarily as: a convalescent home, convalescent, rest, or nursing facility; or a facility primarily affording custodial or educational care; or a facility for the aged.

HOSPITAL CONFINEMENT / CONFINEMENT / CONFINED means being an inpatient in a Hospital for necessary care and treatment of childbirth. Such Confinement must be for the Covered Pregnancy and must be prescribed by a Physician. Confinement does not include outpatient care and treatment, including outpatient surgery or outpatient observation received in a Hospital.

INSURED means you, the insured named in the Policy Schedule, provided coverage has become effective.

NECESSARY TREATMENT means medical treatment which is consistent with currently accepted medical practice. Any Confinement which is not a valid course of treatment recognized by an established medical society in the United States is not considered “Necessary Treatment.” We may use Peer Review Organizations or other professional medical opinions to determine if the Confinement is medically necessary, consistent with professionally recognized standards of care. If the Confinement does not meet these criteria, the Confinement will not be deemed “Necessary Treatment”.

PHYSICIAN means a person who is duly licensed and legally qualified to diagnose and treat pregnancy and childbirth. Such person must be providing services within the scope of his or her license. A physician may not be you or a member of your immediate family.

WHEN YOUR INSURANCE BEGINS

Your coverage takes effect on the Policy Effective Date shown on the Policy Schedule, provided we have received your Single Premium.

WHEN YOUR INSURANCE ENDS

Your insurance ends on the earliest of the following:
1. your date of discharge for the Hospital Confinement;
2. 60 days after your Scheduled Delivery Date shown on the Policy Schedule;
3. the date the Maximum Benefit Period has been reached; or
4. the date you cancel your coverage.

You may cancel your coverage upon notice to us. Notice is deemed given when made in writing, communicated verbally by telephone or in person, or by any other means acceptable to us. Unless requested otherwise, coverage is cancelled as of the date the cancellation request is made. Any unearned premium is pro-rated from the date of cancellation and refunded to you, only when you cancel coverage before your coverage ends for any other stated reason above.

Cancellation is without prejudice to any claim originating prior to the date of cancellation. No benefits are paid for any loss which occurs after the date your coverage stops.

BENEFITS

HOSPITAL CONFINEMENT FOR MATERNITY BENEFIT: In the event a Hospital Confinement is for childbirth of a Covered Pregnancy, we will pay the Hospital Confinement for Maternity Benefit stated on the Policy Schedule for each day you are Confined for at least 24 hours, subject to any Benefit Waiting Period stated on the Policy Schedule. In order to receive this benefit, you must: (1) be Confined for the Covered Pregnancy; (2) be continuously Confined for Necessary Treatment; and (3) be insured under this Policy before the Confinement begins. You will receive this benefit for as long as you are continuously Confined up to the Maximum Benefit Period stated on the Policy Schedule.

Exclusion: No benefit shall be paid for loss that results from any Confinement other than Confinement for childbirth.

PREMIUM

The Single Premium due by the terms of this Policy is stated on your Policy Schedule. The premium shall be paid to our Administrative Office on or prior to the Policy Effective Date.

A refund of unearned premium shall be payable to your beneficiary in the event of your death. Unearned premium is any amount paid by you beyond the date of your death. Any unearned premium refund shall be paid in a lump sum no later than 30 days after Proof of Loss has been furnished to us.

CLAIM PROVISIONS

NOTICE OF CLAIM: Written Notice of Claim must be given to us within 30 days after any loss covered under this Policy occurs or as soon as possible thereafter. You may give the notice or may have someone do it for you. The notice should include your name and Policy Number as shown on the Policy Schedule. Notice should be mailed to us at our Administrative Office.

CLAIM FORMS: When we receive the Notice of Claim, we will send the claimant forms for filing Proof of Loss. If we do not send the forms within 15 days, the claimant can meet the Proof of Loss requirement by providing us with a written statement describing the loss. We must receive this statement within the time given for Proof of Loss.

PROOF OF LOSS: Written Proof of Loss must be given to us within 90 days after the date of the loss or as soon as possible thereafter. Proof must, however, be furnished no later than one year from the time it is otherwise required, except in the absence of legal capacity.

TIME PAYMENT OF CLAIMS: We will pay all benefits covered by this Policy as soon as we receive proper written Proof of Loss sufficient to determine liability.

PAYMENT OF CLAIMS: Any benefits payable will be paid to you, if living. Any benefits unpaid at your death will be paid as follows: to your spouse, if living; otherwise, equally to your then living lawful children, including step-children and adopted children, if any; otherwise, equally to your then living parents or parent; otherwise, to your estate.

PHYSICAL EXAM: At our expense, we shall have the right to examine you when and as often as is reasonable while a claim is pending.

GENERAL PROVISIONS

ENTIRE CONTRACT: This Policy, your application, and any papers attached by us to any such documents constitute the entire contract. All statements made by you shall be deemed representations and not warranties. No statement made by you shall be used in any contest or in defense of a claim hereunder unless a copy of the instrument containing the statement is or has been furnished to you. No agent may change or waive any provisions of this Policy. Any change in this Policy must be in the form of an amendment or endorsement signed by one of our officers.

INCONTESTABILITY: No misstatements, except fraudulent misstatements, made by you in the application form for this Policy shall be used to void this Policy or deny a claim for loss.

LEGAL ACTIONS: No action can be brought to recover on this Policy for at least 60 days after written Proof of Loss has been furnished. No such action shall be brought more than 3 years after the date Proof of Loss is required.

CONFORMITY WITH STATE STATUTES: If any part of this Policy conflicts with the law of the state of delivery on the date this Policy goes into effect, this Policy is amended to meet the minimum requirements of such law.

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirements of coverage by Worker's Compensation insurance.

[LIMITED BENEFIT HOSPITAL INSURANCE APPLICATION FORM]

[YES **[**Please enroll me for this Protection.**]]**

I understand that in order to enroll for this coverage, I, the applicant, must:

1. Be a customer of **[**Destination Maternity Corporation**]**;
2. Be between the ages of 18 through 50, and reside in a state in which this insurance plan may legally be offered;
3. Be pregnant at the time of application.

My Scheduled Delivery Date is **[**_____**]**.

Name **[**Jane Doe**]** Insured's Date of Birth **[**01 / 20 / 74**]**

Address **[**123 Any Street**]**

City, ST ZIP Code **[**Any City, State 11111-1111**]** Home Telephone # (**[**111**]**) **[**555-1234**]**

Will this Policy replace any accident and health insurance policy that you now have in force? **o** Yes **o** No

I understand that when my application form and premium of $**[**X.XX**]** are received, a Policy will be sent to me and will be effective on the date stated on my Policy Schedule. **[**I have read the fraud notice **[**on the back of this enrollment form**]** as it applies to my state of residence.

X [Jane Doe] Date [01 / 07 / 09]
Insured's Signature - **Required**

Stonebridge Life Insurance Company
Home Office: Rutland, Vermont /Administrative Offices: **[**2700 West Plano Parkway, Plano, Texas 75075-8200**]**

SLHI2000IA

[Residents of ARKANSAS, NEW MEXICO, and OHIO: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.**]**

[Residents of DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.**]**

[Residents of FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**]**

[Residents of KENTUCKY: Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement or claim containing any false, incomplete, or misleading information is guilty of a felony.**]**

[Residents of LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**]**

[Residents of MAINE and TENNESSEE and WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.**]**

[Residents of MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**]**

[Residents of NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.**]**

[Residents of NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**]**

[Residents of PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**]**

STONEBRIDGE LIFE INSURANCE COMPANY

A STOCK COMPANY
Home Office: Rutland, Vermont
Administrative Office: [2700 West Plano Parkway, Plano, Texas 75075**]**
Toll Free Number [1-800-527-9027**]**

LIMITED BENEFIT HOSPITAL INSURANCE
OUTLINE OF COVERAGE
POLICY FORM: SLHI2000IP.AR

1. **READ YOUR POLICY CAREFULLY.** This outline of coverage provides a brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. If is, therefore, important that you READ YOUR POLICY CAREFULLY.

2. **LIMITED BENEFIT HOSPITAL INSURANCE.** This policy is designed to provide you with limited hospital confinement coverage, it provides benefit amounts which are less than those prescribed by the insurance regulatory authority of your state as minimum benefit amounts for this type of coverage. Coverage is provided for the benefits outlined in paragraph (3). The benefits described in paragraph (3) may be limited by paragraph (4).

3. **BENEFITS.**

HOSPITAL CONFINEMENT
BENEFIT FOR MATERNITY: $ **[**10-1,000 - selected by you, shown on your Schedule**]** per day
BENEFIT WAITING PERIOD: **[**3-7, selected by you, shown on your Schedule**]** days after vaginal birth
[4-7, selected by you, shown on your Schedule**]** days after caesarian birth
MAXIMUM BENEFIT PERIOD: **[**5-30, selected by you, shown on your Schedule**]** days after Benefit Waiting Period

In the event a Hospital Confinement is for childbirth of a Covered Pregnancy, we will pay the Hospital Confinement for Maternity Benefit stated on the Policy Schedule for each day you are Confined for at least 24 hours, subject to any Benefit Waiting Period stated on the Policy Schedule. In order to receive this benefit, you must: (1) be Confined for the Covered Pregnancy; (2) be continuously Confined for Necessary Treatment; and (3) be insured under this Policy before the Confinement begins. You will receive this benefit for as long as you are continuously Confined up to the Maximum Benefit Period stated on the Policy Schedule.

A **COVERED PREGNANCY** means your pregnancy at the time your coverage goes into effect.

A **HOSPITAL CONFINEMENT / CONFINEMENT / CONFINED** means being an inpatient in a Hospital for necessary care and treatment of childbirth. Such Confinement must be for the Covered Pregnancy and must be prescribed by a Physician. Confinement does not include outpatient care and treatment, including outpatient surgery or outpatient observation received in a Hospital.

4. **EXCLUSIONS, LIMITATIONS, and REGULATIONS.**

Benefits are subject to any Benefit Waiting Period (a period of consecutive days of Hospital Confinement after birth for which no benefit is payable; it begins on the day you give birth during a Hospital Confinement for the Covered Pregnancy) shown on the Policy Schedule and Maximum Benefit Period stated on the Policy Schedule.

Exclusion: No benefit shall be paid for loss that results from any Confinement other than Confinement for childbirth.

5. RENEWABILITY.

The policy is noncancelable - you may keep this Policy in force, for as long as you live, subject to the When Your insurance Ends Provision. We can not cancel your coverage. The Policy is not renewable. The Policy will remain in force until the conditions set forth in the When Your insurance Ends Provision occur.

WHEN YOUR INSURANCE ENDS: Your insurance ends on the earliest of the following:

1. your date of discharge for the Hospital Confinement;
2. 60 days after your Scheduled Delivery Date shown on the Policy Schedule;
3. the date the Maximum Benefit Period has been reached; or
4. the date you cancel your coverage.

You may cancel your coverage upon notice to us. Notice is deemed given when made in writing, communicated verbally by telephone or in person, or by any other means acceptable to us. Unless requested otherwise, coverage is cancelled as of the date the cancellation request is made. Any unearned premium is pro-rated from the date of cancellation and refunded to you, only when you cancel coverage before your coverage ends for any other stated reason above.

Cancellation is without prejudice to any claim originating prior to the date of cancellation. No benefits are paid for any loss which occurs after the date your coverage stops.

5. PREMIUM. The Single Premium, shown on your Policy Schedule, shall be paid to our Administrative Office on or prior to the Policy Effective Date.

A refund of unearned premium shall be payable to your beneficiary in the event of your death. Unearned premium is any amount paid by you beyond the date of your death. Any unearned premium refund shall be paid in a lump sum no later than 30 days after Proof of Loss has been furnished to us.

SERFF Tracking Number:	*AEGX-126244057*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*43046*
Company Tracking Number:	*HH AR0046715C01*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*Limited Benefit*		
Project Name/Number:	*Limited Benefit/HH AR0046715C01*		

Rate Information

Rate data applies to filing.

Filing Method: Prior Approval

Rate Change Type:

Overall Percentage of Last Rate Revision:

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Stonebridge Life Insurance Company	%	%				%	%

SERFF Tracking Number:	*AEGX-126244057*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*43046*
Company Tracking Number:	*HH AR0046715C01*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*Limited Benefit*		
Project Name/Number:	*Limited Benefit/HH AR0046715C01*		

Rate/Rule Schedule

Review Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate ActionInformation:	Attachments
Approved-Closed	Limited Benefit Hospital Insurance Actuarial Rate Sheet	SLHI2000IP	New		HH AR0046715C01.PDF

ACTUARIAL RATE SHEET

Stonebridge Life Insurance Company

SLHI2000IP

LIMITED BENEFIT INSURANCE
single premiums per $100 daily benefit

Waiting Period (days)		
Vaginal Birth	Caesarian Birth	Premiums
3	4	9.920
4	5	6.200
5	6	4.540
6	7	3.210
7	7	2.880

(1) Sum of all benefits, & round to the near dollar.

SERFF Tracking Number:	*AEGX-126244057*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*43046*
Company Tracking Number:	*HH AR0046715C01*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*Limited Benefit*		
Project Name/Number:	*Limited Benefit/HH AR0046715C01*		

Supporting Document Schedules

Satisfied -Name: Flesch Certification

Review Status: Approved-Closed 08/05/2009

Comments:

Attachment:

AR - READABILITY CERTIFICATION.PDF

Satisfied -Name: Application

Review Status: Approved-Closed 08/05/2009

Comments:

See Form Schedule

Satisfied -Name: Health - Actuarial Justification

Review Status: Approved-Closed 08/05/2009

Comments:

Attachment:

Actuarial Memorandum.PDF

Satisfied -Name: Outline of Coverage

Review Status: Approved-Closed 08/05/2009

Comments:

See Form Schedule

Satisfied -Name: AR - NAIC TRANSMITTAL DOCUMENT, AR - NAIC FORM FILING ATTACHMENT, AR - NAIC RATE FILING ATTACHMENT

Review Status: Approved-Closed 08/05/2009

Comments:

Attachments:

AR - NAIC TRANSMITTAL DOCUMENT.PDF

AR - NAIC FORM FILING ATTACHMENT.PDF

AR - NAIC RATE FILING ATTACHMENT.PDF

SERFF Tracking Number:	*AEGX-126244057*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*43046*
Company Tracking Number:	*HH AR0046715C01*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*Limited Benefit*		
Project Name/Number:	*Limited Benefit/HH AR0046715C01*		

Satisfied -Name: Explanation of Variability

Review Status:
Approved-Closed 08/05/2009

Comments:

Attachment:
Explanation of Variability.PDF

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: **Stonebridge Life Insurance Company**

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
SLHI2000IP	46
SLHI2000IA	40
SLHI2000IOC	40

Signed: _____

Name: Edward G. Weigand

Title: Assistant Secretary

Date: 07-27-09

STONEBRIDGE LIFE INSURANCE COMPANY
ACTUARIAL MEMORANDUM

LIMITED BENEFIT POLICY Form SLHI2000IP

I. Product Description

This policy provides a daily benefit for each day of confinement for care and treatment of childbirth for the covered pregnancy. The benefit will begin after a specified waiting period after birth.

This policy is guaranteed issue and nonrenewable. Issue ages are 18-50.

This product will be offered via direct marketing channels, such as Internet, direct mail and telemarketing.

II. The gross premiums for the policy form are based upon the following assumptions:

A. Expenses

Marketing Expenses And Service Fees	Not greater than 100% of Issued Annualized Premium
Billing Charges	$0.26/per bill plus 1.73% of premium
Customer Service	$6.26/per year inforce
Claims Paying Expense	2.00% of claims
Operational Fixed Costs	2.01% of premium
Premium Tax	2.50% of premium

E. Claim Cost is based on data from the National Hospital Discharge Survey.

F. Loss Ratio

The anticipated loss ratio on the present form is 50%.

The loss-ratio is therefore satisfactory.

III. Gross Premium

The gross rates are illustrative and will vary based on the actual combination of benefits offered. We reserve the right to change the table of rates prospectively.

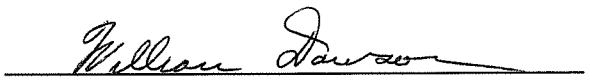
The gross rates based on the assumptions in this memorandum are attached.

IV. Certification

The rates, benefits and policy provision having been carefully analyzed, it is hereby certified that:

- the issuance of this policy is not contrary to the best interest of the public;
- the issuance of this policy would be actuarially sound;
- the benefits are reasonable in relation to the premiums charged;
- this rate filing is in compliance with the applicable laws and regulations of this state.

I hereby certify that the above information is true to the best of my knowledge and belief



William Dawson, FSA, MAAA
Actuary
July 21, 2009

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	**Prepared for the State of**	Arkansas

2.	**Department Use Only**
	State Tracking ID

3. **Insurer Name & Address**	**Domicile**	**Insurer License Type**	**NAIC Group #**	**NAIC #**	**FEIN #**	**State #**
Stonebridge Life Insurance Company 29 South Main Street Rutland VT 05701-5014	VT	A&H	468	65021	03-0164230	N/A

4. **Contact Name & Address**	**Telephone #**	**Fax #**	**E-mail Address**
Kimberly Taylor, AIRC, ACS 520 Park Avenue, MS #A507 Baltimore MD 21201	800-233-4624, ext. 5261	410-209-5910	kimtaylor@aegonusa.com

5.	**Requested Filing Mode**	☒ Review & Approval ☐ File & Use ☐ Informational ☐ Combination (please explain): _____ ☐ Other (please explain): _____

6.	**Company Tracking Number**	HH AR0046715C01
7.	☒ **New Submission** ☐ **Resubmission**	Previous file # _____
8.	**Market**	☒ Individual ☐ Franchise Group: ☐ Small ☐ Large ☐ Small and Large ☐ Employer ☐ Association ☐ Blanket ☐ Discretionary ☐ Trust ☐ Other: _____
9.	**Type of Insurance**	H14I Individual Health - Hospital Indemnity
10.	**Product Coding Matrix Filing Code**	H14I.000 Health - Hospital Indemnity
11.	**Submitted Documents**	☒ **FORMS** ☒ Policy ☒ Outline of Coverage ☐ Certificate ☒ Application/Enrollment ☐ Rider/Endorsement ☐ Advertising ☐ Schedule of Benefits ☐ Other: _____ ☒ **RATES** ☒ New Rate ☐ Revised Rate ☐ **FILING OTHER THAN FORM OR RATE:** Please explain: _____ **SUPPORTING DOCUMENTATION** ☐ Articles of Incorporation ☐ Third Party Authorization ☐ Association Bylaws ☐ Trust Agreement ☒ Statement of Variability ☒ Certifications ☒ Actuarial Memorandum ☐ Other: _____

12.	**Filing Submission Date**	07-27-09
13.	**Filing Fee (If required)**	Amount $100.00 Check Date Submit via EFT Retaliatory ☐ Yes ☒ No Check Number
14.	**Date of Domiciliary Approval**	Currently pending review in domicile state.
15.	**Filing Description:**	

The Limited Benefit Hospital Insurance Policy and related materials are being submitted for your review and approval. These forms are new and do not replace any forms previously approved by your department. These forms have been completed in "John Doe" fashion.

This individual policy provides a daily benefit for each day of confinement for care and treatment of childbirth for a covered pregnancy. The benefit will begin after a specified waiting period after the birth which can vary by type of delivery. The policy is guaranteed issue and non-cancelable.

Bracketed information throughout the policy and application form is intended to be variable. An explanation of variability is included.

The product will be marketed via direct response means, including mail, telephone solicitation and internet. We intend to use an electronic signature process for the customer's signature of the enrollment form in the telephone and internet channels, and will maintain records of sales of this product in a secure electronic format.

We trust with the enclosed information, you will be able to review our filing and grant an approval. If you have any questions, please contact the undersigned. Thank you in advance for your attention to this filing.

16. Certification (If required)

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of Arkansas.

Print Name Kimberly Taylor, AIRC, ACS Title Filing Specialist

Signature Kimberly Taylor Date 07-27-09

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	HH AR0046715C01
This filing corresponds to rate filing company tracking number	HH AR0046715C01

	Document Name Description	Form Number		Replaced Form Number Previous State Filing Number
01	Limited Benefit Hospital Insurance Policy Policy	SLHI2000IP	☒ Initial ☐ Revised ☐ Other _____	
02	Limited Benefit Hospital Insurance Application Application	SLHI2000IA	☒ Initial ☐ Revised ☐ Other _____	
03	Limited Benefit Hospital Insurance Outline of Coverage Outline of Coverage	SLHI2000IOC	☒ Initial ☐ Revised ☐ Other _____	
04			☐ Initial ☐ Revised ☐ Other _____	
05			☐ Initial ☐ Revised ☐ Other _____	
06			☐ Initial ☐ Revised ☐ Other _____	
07			☐ Initial ☐ Revised ☐ Other _____	
08			☐ Initial ☐ Revised ☐ Other _____	
09			☐ Initial ☐ Revised ☐ Other _____	
10			☐ Initial ☐ Revised ☐ Other _____	
11			☐ Initial ☐ Revised ☐ Other _____	

18.	Rate Filing Attachment			
This filing transmittal is part of company tracking number			HH AR0046715C01	
This filing corresponds to form filing company tracking number			HH AR0046715C01	
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing			Not Applicable **%**	
	Document Name **Description**	**Affected Form Numbers**		**Previous State Filing Number**
01	Limited Benefit Hospital Insurance Actuarial Rate Sheet	SLHI2000IP	☒ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
02	Actuarial Memorandum	SLHI2000IP	☒ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
03			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
04			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
05			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
06			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
07			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
08			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
09			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
10			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
11			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	
12			☐ **New** ☐ **Revised** **Request +** _____ % - _____ % ☐ **Other**	

EXPLANATION OF VARIABLE ITEMS

Form SLHI2000IP – Limited Benefit Hospital Insurance Policy

Page 1:

- *Administrative Office* address and phone number will appear as shown. This item may vary depending on the location and phone number of the office that will administer the policy.

Page 2 Policy Schedule Data:

- The INSURED, POLICY NUMBER, SINGLE PREMIUM, POLICY EFFECTIVE DATE, SCHEDULED DELIVERY DATE, HOSPITAL CONFINEMENT BENEFIT FOR MATERNITY, BENEFIT WAITING PERIOD, and MAXIMUM BENEFIT PERIOD data will vary to reflect the insured's unique information.
- The HOSPITAL CONFINEMENT BENEFIT FOR MATERNITY will vary to reflect the specific benefit selected by the policyholder or the insured; range from $10 per day to $1,000 per day; benefit configuration as selected by insured.
- The BENEFIT WAITING PERIOD will vary to reflect the specific Benefit Waiting Period selected by the policyholder or the insured; days after vaginal birth, range from 3 to 7 days; days after caesarian birth, range from 4 to 7 days; or days after initial day of confinement, range from 3 to 7 days; Benefit Waiting Period components as selected by insured.
- The MAXIMUM BENEFIT PERIOD will vary to reflect the specific Maximum Benefit Period; range from 5 to 30 days as selected by insured.

Form SLHI2000IOC – Outline of Coverage

Page 1:

- *Administrative Office* address and phone number will appear as shown. This item may vary depending on the location and phone number of the office that will administer the policy.

Page 1 Benefit Data:

- The benefit data will either match the Insured's specific benefit configuration or state [as shown on your Schedule].

Form SLHI2000IA –Limited Benefit Hospital Application Form

- Declarative statements will appear as shown and be consistent with the product offered under the policy and approved by the Company.
- *Administrative Office* address and phone number will appear as shown. This item may vary depending on the location and phone number of the office that will administer the policy.
- Placement of various items will vary based on the design of the application as tailored to the policyholder's benefit configuration and approved by the Company.
- The *Name*, *Address*, *City, State, Zip Code* , *Date of Birth*, and *Telephone Number* items will be completed by the enrollee and vary accordingly.

[Fraud Warning paragraph:

- Fraud Warning paragraph will appear as shown as it applies to the enrollee's state of residence or may be deleted in their entirety.**] – Include if applicable.**

SERFF Tracking Number:	*AEGX-126244057*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*43046*
Company Tracking Number:	*HH AR0046715C01*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*Limited Benefit*		
Project Name/Number:	*Limited Benefit/HH AR0046715C01*		

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Limited Benefit Hospital Insurance Outline of Coverage	07/27/2009	SLHI2000IOC.PDF
No original date	Form	Limited Benefit Hospital Insurance Policy	07/27/2009	SLHI2000IP.PDF

STONEBRIDGE LIFE INSURANCE COMPANY

A STOCK COMPANY
Home Office: Rutland, Vermont
Administrative Office: [2700 West Plano Parkway, Plano, Texas 75075**]**
Toll Free Number [1-800-527-9027**]**

LIMITED BENEFIT HOSPITAL INSURANCE
OUTLINE OF COVERAGE
POLICY FORM: SLHI2000IP

1. **READ YOUR POLICY CAREFULLY.** This outline of coverage provides a brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. If is, therefore, important that you READ YOUR POLICY CAREFULLY.

2. **LIMITED BENEFIT HOSPITAL INSURANCE.** This policy is designed to provide you with limited hospital confinement coverage, it provides benefit amounts which are less than those prescribed by the insurance regulatory authority of your state as minimum benefit amounts for this type of coverage. Coverage is provided for the benefits outlined in paragraph (3). The benefits described in paragraph (3) may be limited by paragraph (4).

3. **BENEFITS.**

HOSPITAL CONFINEMENT
BENEFIT FOR MATERNITY: $ **[**10-1,000 - selected by you, shown on your Schedule**]** per day
BENEFIT WAITING PERIOD: **[**3-7, selected by you, shown on your Schedule**]** days after vaginal birth
[4-7, selected by you, shown on your Schedule**]** days after caesarian birth
MAXIMUM BENEFIT PERIOD: **[**5-30, selected by you, shown on your Schedule**]** days after Benefit Waiting Period

In the event a Hospital Confinement is for childbirth of a Covered Pregnancy, we will pay the Hospital Confinement for Maternity Benefit stated on the Policy Schedule for each day you are Confined for at least 24 hours, subject to any Benefit Waiting Period stated on the Policy Schedule. In order to receive this benefit, you must: (1) be Confined for the Covered Pregnancy; (2) be continuously Confined for Necessary Treatment; and (3) be insured under this Policy before the Confinement begins. You will receive this benefit for as long as you are continuously Confined up to the Maximum Benefit Period stated on the Policy Schedule.

A **COVERED PREGNANCY** means your pregnancy at the time your coverage goes into effect.

A **HOSPITAL CONFINEMENT / CONFINEMENT / CONFINED** means being an inpatient in a Hospital for necessary care and treatment of childbirth. Such Confinement must be for the Covered Pregnancy and must be prescribed by a Physician. Confinement does not include outpatient care and treatment, including outpatient surgery or outpatient observation received in a Hospital.

4. **EXCLUSIONS, LIMITATIONS, and REGULATIONS.**

Benefits are subject to any Benefit Waiting Period (a period of consecutive days of Hospital Confinement after birth for which no benefit is payable; it begins on the day you give birth during a Hospital Confinement for the Covered Pregnancy) shown on the Policy Schedule and Maximum Benefit Period stated on the Policy Schedule.

Exclusion: No benefit shall be paid for loss that results from any Confinement other than Confinement for childbirth.

5. RENEWABILITY.

The policy is noncancelable - you may keep this Policy in force, for as long as you live, subject to the When Your insurance Ends Provision. We can not cancel your coverage. The Policy is not renewable. The Policy will remain in force until the conditions set forth in the When Your insurance Ends Provision occur.

WHEN YOUR INSURANCE ENDS: Your insurance ends on the earliest of the following:

1. your date of discharge for the Hospital Confinement;
2. 60 days after your Scheduled Delivery Date shown on the Policy Schedule;
3. the date the Maximum Benefit Period has been reached; or
4. the date you cancel your coverage.

You may cancel your coverage upon notice to us. Notice is deemed given when made in writing, communicated verbally by telephone or in person, or by any other means acceptable to us. Unless requested otherwise, coverage is cancelled as of the date the cancellation request is made. Any unearned premium is pro-rated from the date of cancellation and refunded to you, only when you cancel coverage before your coverage ends for any other stated reason above.

Cancellation is without prejudice to any claim originating prior to the date of cancellation. No benefits are paid for any loss which occurs after the date your coverage stops.

5. PREMIUM. The Single Premium, shown on your Policy Schedule, shall be paid to our Administrative Office on or prior to the Policy Effective Date.

STONEBRIDGE LIFE INSURANCE COMPANY

A STOCK COMPANY
Home Office: Rutland, Vermont
Administrative Office: [2700 West Plano Parkway, Plano, Texas 75075**]**
Toll Free Number [1-800-527-9027**]**

LIMITED BENEFIT HOSPITAL INSURANCE POLICY

Stonebridge Life Insurance Company (herein called "we", "us" or "our") has issued this Policy to the Insured (herein called "you", "your", or "yours"). Coverage is provided to you, the Insured, subject to all terms of this Policy.

TABLE OF CONTENTS

NONCANCELABLE – SINGLE TERM NONRENEWABLE POLICY

You may keep this Policy in force, for as long as you live, subject to the When Your insurance Ends Provision. We can not cancel your coverage.

This Policy is not renewable. This Policy will remain in force until the conditions set forth in the When Your insurance Ends Provision occur. Please read the When Your insurance Ends Provision carefully.

YOUR RIGHT TO EXAMINE THE POLICY

If you are not satisfied with this insurance, you may return this Policy and cancel your coverage for any reason within 30 days of the date you receive this Policy. You may return this Policy to our Administrative Office. You will receive a full refund of any premium you have paid. The Policy is treated as if it never existed. No benefits are paid.

IN WITNESS, this Policy is signed by our President and Secretary.

Craig D. Vermie
Secretary

Marilyn Carp
President

THIS POLICY PROVIDES LIMITED BENEFITS ONLY

PLEASE READ CAREFULLY

POLICY SCHEDULE

INSURED: **[**Jane Doe**]**

POLICY NUMBER: **[**C12345**]** **SINGLE PREMIUM:** **[**$50.00**]**

POLICY EFFECTIVE DATE: **[**04-01-2009**]**

SCHEDULED DELIVERY DATE: **[**09-01-2009**]**

HOSPITAL CONFINEMENT BENEFIT FOR MATERNITY: $**[**50**]** per day
BENEFIT WAITING PERIOD: **[[**3**]** days after vaginal birth
[4**]** days after caesarian birth**]**
[7**]** days**]]**
MAXIMUM BENEFIT PERIOD: **[**30**]** days after Benefit Waiting Period

---

DEFINITIONS

BENEFIT WAITING PERIOD means a period of consecutive days of Hospital Confinement after birth for which no benefit is payable. The Benefit Waiting Period begins on the day you give birth during a Hospital Confinement for the Covered Pregnancy. The Benefit Waiting Period is shown on the Policy Schedule.

COVERED PREGNANCY means your pregnancy at the time your coverage goes into effect.

HOSPITAL means an institution which meets the following requirements:
1. It is operated pursuant to law; and
2. It is primarily engaged in providing or operating either on its premises or in facilities available to the Hospital on a prearranged basis and under supervision of a staff of one or more duly licensed Physicians, medical, diagnostic, and major surgical facilities for medical care and treatment of sick and injured persons on an inpatient basis; and
3. It provides 24 hour nursing service by or under the supervision of registered graduate professional nurses (R.N.s).

Hospital does not include an institution operated primarily as: a convalescent home, convalescent, rest, or nursing facility; or a facility primarily affording custodial or educational care; or a facility for the aged, drug addicts, or alcoholics. Hospital also does not include that part of an institution operated primarily as: a convalescent home, convalescent, rest, or nursing facility; or a facility primarily affording custodial or educational care; or a facility for the aged.

HOSPITAL CONFINEMENT / CONFINEMENT / CONFINED means being an inpatient in a Hospital for necessary care and treatment of childbirth. Such Confinement must be for the Covered Pregnancy and must be prescribed by a Physician. Confinement does not include outpatient care and treatment, including outpatient surgery or outpatient observation received in a Hospital.

INSURED means you, the insured named in the Policy Schedule, provided coverage has become effective.

NECESSARY TREATMENT means medical treatment which is consistent with currently accepted medical practice. Any Confinement which is not a valid course of treatment recognized by an established medical society in the United States is not considered “Necessary Treatment.” We may use Peer Review Organizations or other professional medical opinions to determine if the Confinement is medically necessary, consistent with professionally recognized standards of care. If the Confinement does not meet these criteria, the Confinement will not be deemed “Necessary Treatment”.

PHYSICIAN means a person who is duly licensed and legally qualified to diagnose and treat pregnancy and childbirth. Such person must be providing services within the scope of his or her license. A physician may not be you or a member of your immediate family.

WHEN YOUR INSURANCE BEGINS

Your coverage takes effect on the Policy Effective Date shown on the Policy Schedule, provided we have received your Single Premium.

WHEN YOUR INSURANCE ENDS

Your insurance ends on the earliest of the following:
1. your date of discharge for the Hospital Confinement;
2. 60 days after your Scheduled Delivery Date shown on the Policy Schedule;
3. the date the Maximum Benefit Period has been reached; or
4. the date you cancel your coverage.

You may cancel your coverage upon notice to us. Notice is deemed given when made in writing, communicated verbally by telephone or in person, or by any other means acceptable to us. Unless requested otherwise, coverage is cancelled as of the date the cancellation request is made. Any unearned premium is pro-rated from the date of cancellation and refunded to you, only when you cancel coverage before your coverage ends for any other stated reason above.

Cancellation is without prejudice to any claim originating prior to the date of cancellation. No benefits are paid for any loss which occurs after the date your coverage stops.

BENEFITS

HOSPITAL CONFINEMENT FOR MATERNITY BENEFIT: In the event a Hospital Confinement is for childbirth of a Covered Pregnancy, we will pay the Hospital Confinement for Maternity Benefit stated on the Policy Schedule for each day you are Confined for at least 24 hours, subject to any Benefit Waiting Period stated on the Policy Schedule. In order to receive this benefit, you must: (1) be Confined for the Covered Pregnancy; (2) be continuously Confined for Necessary Treatment; and (3) be insured under this Policy before the Confinement begins. You will receive this benefit for as long as you are continuously Confined up to the Maximum Benefit Period stated on the Policy Schedule.

Exclusion: No benefit shall be paid for loss that results from any Confinement other than Confinement for childbirth.

PREMIUM

The Single Premium due by the terms of this Policy is stated on your Policy Schedule. The premium shall be paid to our Administrative Office on or prior to the Policy Effective Date.

CLAIM PROVISIONS

NOTICE OF CLAIM: Written Notice of Claim must be given to us within 30 days after any loss covered under this Policy occurs or as soon as possible thereafter. You may give the notice or may have someone do it for you. The notice should include your name and Policy Number as shown on the Policy Schedule. Notice should be mailed to us at our Administrative Office.

CLAIM FORMS: When we receive the Notice of Claim, we will send the claimant forms for filing Proof of Loss. If we do not send the forms within 15 days, the claimant can meet the Proof of Loss requirement by providing us with a written statement describing the loss. We must receive this statement within the time given for Proof of Loss.

PROOF OF LOSS: Written Proof of Loss must be given to us within 90 days after the date of the loss or as soon as possible thereafter. Proof must, however, be furnished no later than one year from the time it is otherwise required, except in the absence of legal capacity.

TIME PAYMENT OF CLAIMS: We will pay all benefits covered by this Policy as soon as we receive proper written Proof of Loss sufficient to determine liability.

PAYMENT OF CLAIMS: Any benefits payable will be paid to you, if living. Any benefits unpaid at your death will be paid as follows: to your spouse, if living; otherwise, equally to your then living lawful children, including step-children and adopted children, if any; otherwise, equally to your then living parents or parent; otherwise, to your estate.

PHYSICAL EXAM: At our expense, we shall have the right to examine you when and as often as is reasonable while a claim is pending.

GENERAL PROVISIONS

ENTIRE CONTRACT: This Policy, your application, and any papers attached by us to any such documents constitute the entire contract. All statements made by you shall be deemed representations and not warranties. No statement made by you shall be used in any contest or in defense of a claim hereunder unless a copy of the instrument containing the statement is or has been furnished to you. No agent may change or waive any provisions of this Policy. Any change in this Policy must be in the form of an amendment or endorsement signed by one of our officers.

INCONTESTABILITY: No misstatements, except fraudulent misstatements, made by you in the application form for this Policy shall be used to void this Policy or deny a claim for loss.

LEGAL ACTIONS: No action can be brought to recover on this Policy for at least 60 days after written Proof of Loss has been furnished. No such action shall be brought more than 3 years after the date Proof of Loss is required.

CONFORMITY WITH STATE STATUTES: If any part of this Policy conflicts with the law of the state of delivery on the date this Policy goes into effect, this Policy is amended to meet the minimum requirements of such law.

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirements of coverage by Worker's Compensation insurance.